

letters

A case of urinary bladder benign polyp treated successfully by resection in a child

To the Editor: We report a case of a 3-year old boy that presented with recurrent urine retention secondary to a bladder polyp. Acute urine retention is not common in children. It may be secondary to dysuria whether from urinary tract infection, vaginitis, meatal ulcer, severe constipation with fecal masses compressing the bladder neck, voiding dysfunction, or from medications such as sympathomimetics.¹ Urethral obstructive lesions such as valves or stones may present with acute urine retention. Bladder polyps, however, are a very rare cause of acute urine retention in children.

The boy was admitted to the Jordan University Hospital with recurrent acute urine retention and painless gross hematuria of 1-weeks duration. There was a history of urinary frequency, urgency, and suprapubic pain of 2 weeks duration. There was no history of a urine catheter. Physical examination was noncontributory. Urine analysis and culture were negative. A 24-hour urine collection revealed hyperoxaluria. A renal ultrasound was nega-

tive.

The patient underwent urethrocystoscopy. There was a mobile greenish soft polypoid pedunculated mass measuring 1.2×0.6×0.5 cm in the bladder dome that was resected. Histopathology revealed an infarcted polyp with polypoid fibrovascular tissue lined by a transitional epithelium lacking nuclear atypia. The stroma was edematous and congested with scanty inflammatory cell infiltrates. There was no evidence of malignancy. The patient had one recurrence of the gross hematuria without recurrence of the polyp as demonstrated on repeat cystoscopy. He was put on pyridoxine for the hyperoxaluria.

Recurrent urine retention in children may result from a variety of causes. However, bladder polyps as a cause are rare. Genitourinary tract polyps can occur anywhere from the renal pelvis to the urethra.²⁻⁵ Bladder polyps are rare in both adults and children. They may present with gross hematuria, voiding dysfunction,⁶ or urine infection.⁷⁻¹⁰ One should always keep in mind malignant tumours such as rhabdomyosarcoma, which may present in a similar manner. Diagnosis is by histopathology. Polyps are usually benign and do not turn malignant or recur. Al Ahmadi and colleagues reported a giant fibroepithelial polyp in a 3-year old child.¹¹ In our patient, the location of the polyp allowed it to act as an intermittent valve, leading to urine retention alternating with symptom-free periods.

The pathogenesis of bladder genitourinary polyps remains to be elucidated. One hypothesis suggests that stone-initiated chronic irritation of the genitourinary mucosa leads to polyp formation.⁵ The role of the stone and crystalluria in the initiation of the localized inflammatory trigger seems appealing.

Murshidi proposed that chronic localized lamina propria edema may cause a mucosal bulge which culminates into a polyp,⁵ but this does not explain the presence of congenital polyps. In our patient, the chronic mucosal irritation with oxalate crystal may have contributed to localized edema and polyp formation.

Mujalli S. Murshidi
Kamal Akl

Correspondence:
Dr. Muhalli S. Murshidi
Department of Urology
Jordan University Hospital
P.O. Box 13245
Amman 11942, Jordan
mujalli_mhailan@hotmail.com

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